PROTECTING HOME & PROPERTY BUYERS

My Protection Plan

PRODUCT DISCLOSURE STATEMENT

& Policy Document

Issued date:
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THIS DOCUMENT EXPLAINS MY PROTECTION PLAN

This Product Disclosure Statement and Policy Document (*PDS*) contains important information about My Protection Plan.

My Protection Plan is an optional insurance product. It provides lump sum payments to help you and your loved ones if you die or suffer a specified illness or injury. You can use the benefit payments for any purpose, including living expenses or helping with medical expenses.

This *PDS* tells you how My Protection Plan works, what it does and doesn't cover, how to make a claim, and how to pay for this product.

My Protection Plan provides three types of cover

This product provides you with the following benefits.

- Death and Terminal Illness
- Trauma
- Specified Injury

For full details of these benefits please see **'The benefits we pay'** on page 14.

Make sure My Protection Plan is right for you

Read this *PDS* carefully before applying for My Protection Plan, to decide whether this product is right for you.

The information in this *PDS* is general. It doesn't take into account your personal objectives, financial situation or needs. You should consider whether this product is appropriate for you and your circumstances. To assist with determining if My Protection Plan is right for you, the target market determination for this product is available at www.aligroup.com.au.

We may update the information in this *PDS* from time to time. If the changes are materially adverse, we will post the updates on the ALI Group website.

You can get the updated information free of charge by:

- visiting www.aligroup.com.au for an online copy
- calling ALI Group on 1800 006 776.

If you buy this product, keep this *PDS* safe with the other documents that make up your policy. You may need to refer to them if you make a claim. You may also be able to access a copy of this *PDS* on www.aligroup.com.au/existing-customers/policy-documents.

Please note, our website is updated regularly and the *PDS* you view online may not be applicable to your policy. You can request a copy of this *PDS* by calling ALI Group.

Several documents make up your policy

A My Protection Plan policy is made up of these documents.

- This *PDS*
- The *Policy Schedule*
- Any other notices we give you in writing, confirming changes to the policy.

Some words in this PDS have a special meaning

In this *PDS*, the words 'you' and 'your' refer to the *policy owner,* except where otherwise stated. Zurich issues the policy to the *policy owner*. The *policy owner* is named on the *policy schedule*. There can be up to two *policy owners*.

The *life insured* is the person who is named as a *life insured* in the *policy schedule*. They are who this policy covers – for example, we will pay a benefit if the *life insured* dies. There can be up to two *life insureds* under a policy.

In this *PDS*, the words 'Zurich', 'we', 'our' and 'us' refer to Zurich Australia Limited, except where otherwise stated.

Other words with special meanings appear in italics

Many other words throughout this *PDS* have special meanings. These words will appear in italics. Find definitions in the section **'Definitions of the terms in this PDS'** on page 36.

Zurich Australia Limited issues My Protection Plan

Zurich Australia Limited (Zurich) ABN 92 000 010 195 AFSL 232510 issues My Protection Plan and this *PDS*. Zurich Australia Limited is a member of the Zurich Insurance Group, a global insurance specialist formed in Switzerland in 1872.

Our contact details are:

Zurich Australia Limited
Locked Bag 994
North Sydney NSW 2059
Phone: 1800 025 015

Zurich will place premiums for this policy in our Statutory Fund No. 2. We pay any claims under this policy from this statutory fund.

As a *policy owner,* you do not receive any profits of Zurich Australia Limited or any surplus of any Zurich Australia Limited Statutory Fund.

ALI Group distributes and administers My Protection Plan

Australian Life Insurance Distribution Pty Ltd (ALID) ABN 31 103 157 811 AFSL 226403 distributes My Protection Plan and is paid a commission by Zurich. Australian Life Insurance Administration Pty Ltd (ALIA) ABN 95 103 157 768 administers My Protection Plan and is paid an administration fee by Zurich. ALID and ALIA are part of the ALI Group of companies (ALI Group). Information about the commission and fee payable by Zurich is in ALID's Financial Services Guide. The commission and fee are not an additional charge to you.

This product is not a deposit or other liability of ALI Group or its related group of companies. None of them stand behind or guarantee Zurich or this product.

ALI Group's contact details are:

ALI Group
GPO Box 4737
Sydney NSW 2001
Phone: 1800 006 776
Email: service@aligroup.com.au

WHAT YOU NEED TO KNOW ABOUT THIS POLICY

To be eligible for My Protection Plan

To be eligible for this policy, each *life insured* must:

- ✓ have or be seeking to take out an *eligible loan*, or be the *partner* of someone who has applied for My Protection Plan
- ✓ be 18 to 59 years old
- ✓ be an Australian or New Zealand citizen, or hold an Australian Permanent Residency Visa
- ✓ have more than $100,000 but no more than $1,000,000 in total Death and Terminal Illness Benefit across all My Protection Plan policies issued by Zurich at the time of the new application (including this policy)
- ✓ have lived in Australia on a permanent basis for at least 6 months continuously during the past 12 months. Being away from Australia for work purposes or holidays does not count for determining if they have lived in Australia continuously.

You must receive this *PDS* in Australia.

You do not have to buy this policy

My Protection Plan is optional insurance. Approval of your application for a loan does not depend on you buying this policy.

There are certain risks when you buy this policy

There are certain risks associated with buying and holding a My Protection Plan policy.

- If you don't pay premiums when they are due, the policy will lapse. This means your cover ends, and your policy is cancelled. You cannot make a claim for events that occur after your policy is cancelled.
- The benefit amounts you choose are important – make sure they are appropriate to provide the cover for your circumstances.
- If you or the *life insured* do not comply with the duty to take reasonable care not to make a

misrepresentation, we may not pay your claim, pay only part of your claim or cancel your cover. See the section **'You must take reasonable care when giving us information'** on this page.

You must take reasonable care when giving us information

When you apply to buy, change or reinstate your My Protection Plan, you have a legal duty to take reasonable care not to make a misrepresentation when answering our questions. Only provide information that is true, accurate and complete, and not false or only partly true.

What may happen if you do not meet your duty

You may face serious consequences if you do not meet your duty. We may:

- adjust your policy so it operates as if you had given us the information you should have given us
- decline or reduce your claim
- avoid your policy (treat your policy as if it never existed)
- change the amount or terms of your cover.

Our aim would be to put us in the same position as if you had met your responsibility.

If you need help

If you do not understand your duty to take reasonable care, please ask ALI Group for help. You can also let us know if you need help because of a disability, because English is not your first language, or for any other reason. You can also have a trusted support person with you when you call, if you need.

Your first 30 days of My Protection Plan are complimentary

To give you time to check your details and make sure My Protection Plan meets your needs, your first 30 days are complimentary. That means in the first year of your policy you will only pay 11 months premium.

Your cover increases automatically

The benefit amounts are automatically increased at each *policy anniversary*. This can help protect the value of the insurance cover over time.

At each *policy anniversary*, the Death and Terminal Illness Benefit amount automatically increases by whichever is greater:

- 3%
- the consumer price index (*CPI*) to a maximum of 10%.

As the cover amounts increase, your premium usually increases.

You can reject the cover increase if you do not want it. To reject the increase, contact us within 30 days of your *policy anniversary*.

A change to your Death and Terminal Illness Benefit amount:

- will also change your Trauma Benefit amount. This is because your Trauma Benefit amount is a percentage of your Death and Terminal Illness Benefit amount.
- may change your Specified Injury Benefit amount. This is because your Specified Injury Benefit amount is 3% of your Death and Terminal Illness Benefit amount, up to $7,500.

You can stop and restart all future automatic increases by sending your request in writing or calling ALI Group on 1800 006 776.

Even if you reject an automatic increase or stop automatic increases, your premiums may still increase due to other factors. Please refer to **'How we calculate your premium'** section on page 26.

You can change your cover amounts

You can ask us to increase or decrease your Death and Terminal Illness Benefit and Trauma Benefit amounts at any time after your policy *start date*.

You can request to increase or decrease your Death and Terminal Illness Benefit to a:

- maximum of $1,000,000
- minimum of $100,000.

You can also increase or decrease your Trauma Benefit to a:

- maximum of 50% of the Death and Terminal Illness Benefit
- minimum of $30,000.

Changes to your benefit amounts will usually change your premiums. You will start paying a new premium once we have accepted your request.

You cannot increase your cover if your premium payments are not up to date.

A change to your Death and Terminal Illness Benefit amount may change your Specified Injury Benefit amount. The Specified Injury Benefit amount is 3% of your Death and Terminal Illness Benefit up to $7,500.

You can have different benefit amounts for each *life insured* this policy covers.

You may choose beneficiaries to receive the death benefit

If you are the sole *policy owner* and *life insured*, you can nominate up to five beneficiaries to receive the death benefit. If you do not nominate any beneficiaries, your death benefit will go to your estate. Your estate will receive any proportion of benefits allocated to a beneficiary if either:

- the beneficiary dies before you do
- your nomination is invalid.

You cannot nominate yourself as a beneficiary. We will pay your death benefit to your estate if

any of the following apply.

- You choose not to make a nomination
- You do not make a valid nomination
- You cancel your existing nomination
- A court order overrides the nomination

Beneficiaries can be individuals only.

If you die and your policy is jointly owned, we pay the Death and Terminal Illness Benefit to the surviving *policy owner*.

Your policy has a start and end date

Your My Protection Plan policy *start date* is the date we accept your application. Your *start date* is shown in your *policy schedule*.

Your My Protection Plan isn't linked to your loan and the policy does not end if your loan stops or you pay it off. However, if you pay off your loan, or the loan is cancelled, you may need to review this policy to make sure it meets your needs.

Your policy will continue for as long as you pay your premiums, regardless of any changes to the *life insured's* health, occupation or pastimes. This means that your policy can continue until the *policy anniversary* after the *life insured* turns 75 years old when the Death and Terminal Illness Benefit under your policy ceases. The Trauma Benefit and Specified Injury Benefit ceases at the *policy anniversary* after the *life insured* turns 65 years.

Your policy also ends as soon as one of the following happens:

- You cancel the policy (see **'Cancelling your policy'** on page 30 for when cancellation is effective)
- The last remaining *life insured* dies
- The last remaining *life insured* is diagnosed with a *terminal illness* and we pay the Death and Terminal Illness Benefit
- We cancel or avoid the policy according to our legal rights
- We cancel the policy because you did not pay your premiums
- The *life insured* is no longer an Australian or New Zealand citizen or an Australian permanent resident

We will tell you before your policy is going to end, except where the *life insured* dies or ceases to be an Australian or New Zealand citizen or an Australian permanent resident, or you cancel the policy.

If a *life insured's* cover ends because of citizenship or residency changes, or age, cover can continue for any other *life insured* if they are still eligible.

No benefits are payable for any event that occurs after the policy ends. This means that if, for example, the diagnosis of *terminal illness* is made after the policy is cancelled, no benefit is payable.

You are not covered under certain circumstances

It's important to know when claims will not be paid so you can decide if My Protection Plan is right for you.

A benefit will not be paid for any claim if an exclusion or qualifying period applies. See **'What we don't cover'** on page 20.

Pre-existing medical conditions affect claims

Any claim arising directly or indirectly from a *pre-existing medical condition* will not be paid.

A *pre-existing medical condition* is an illness, injury or condition that was the subject of a medical consultation in the 5 years immediately before the *policy start date* or a benefit increase date (to the extent of the benefit increase), and:

- the *life insured* was aware of; or
- a reasonable person in the circumstances could be expected to be aware of.

To determine if your claim relates to a *pre-existing medical condition*, we may ask for information about the *life insured's* medical history.

Examples of the effect of pre-existing medical conditions on claims

These examples give an idea of how *pre-existing medical conditions* may apply.

Example: Sian's story

A pre-existing medical condition preventing a claim

Sian bought a My Protection Plan policy and is the *life insured*. Ten months before the policy *start date*, Sian was treated for breast cancer. Because Sian knew she had a breast cancer within the 5 years before she bought the policy, she will not be able to claim for any medical condition directly or indirectly related to her breast cancer.

Example: Aaron's story

A pre-existing medical condition not preventing a claim

Aaron was treated for leukaemia when he was 5 years old. Two years later, his doctors gave him a clean bill of health. Apart from the odd doctor's appointment related to suffering from the cold or flu, he had remained healthy. He bought a My Protection Plan policy at the age of 32 years and is the *life insured*. Aaron's leukaemia returned 10 months after his policy *start date*.

Because Aaron did not have a *medical consultation* relating to his leukaemia nor any symptoms or signs of leukaemia in the 5 years before his policy *start date*, he is eligible to receive a benefit on his policy.

Please note: Examples are illustrations only.

AREA YOUR POLICY COVERS

You are covered anywhere in the world, 24 hours a day, every day of the year, subject to the terms and conditions of this policy.

THE BENEFITS WE PAY

The following sections explain the benefits payable under this policy.

Death and Terminal Illness Benefit

We will pay the Death and Terminal Illness Benefit if your policy is in force and a *life insured* either:

- dies
- is diagnosed with a *terminal illness*.

The amount we pay is the benefit amount shown on your *policy schedule*, at the date the *life insured* dies or is diagnosed as having a *terminal illness*.

We pay the death benefit to the living *policy owner* or *policy owners*. If the *life insured* was the sole *policy owner*, we pay the death benefit to their estate or their nominated beneficiaries (if applicable). We pay the terminal illness benefit to the *policy owner*. The funds may be used for any purpose.

The amount of the benefit may also change over the term of the policy – see **'Your cover increases automatically'** on page 8 and **'You can change your cover amounts'** on page 9.

This benefit provides a funeral advancement payment

If the *life insured* dies, we will pay you $10,000 in advance to cover expenses like funeral costs while we assess your claim. Making a funeral advancement payment does not mean that we will accept your claim.

We subtract this payment from the Death and Terminal Illness Benefit amount shown on your *policy schedule*.

This payment doesn't apply if the benefit for *terminal illness* has been paid.

Trauma Benefit

We will pay the Trauma Benefit if a *medical practitioner* diagnoses a *life insured* with any of the conditions in the list below. Each condition must meet its specific definition under **'Definitions of the terms in this PDS'** on page 36 which also describe the required level of severity.

If the method for diagnosing one of the Trauma conditions has been superseded due to medical advances, we will consider other appropriate and medically recognised methods or tests that unequivocally diagnose the event to at least the same severity.

If a condition on the list appears with an asterisk (*), a 90-day qualifying period applies. This means the condition is not covered if it first occurs, becomes *reasonably apparent* or is first diagnosed in the 90 days after your policy *start date*, *reinstatement date* or benefit increase date. See **'Trauma Benefit qualifying period for certain conditions'** on page 16.

Trauma conditions

Neurological Conditions

- *Alzheimer's disease - dementia (diagnosis and with cognitive impairment)*
- *stroke (of specified severity)**
- *motor neurone disease (diagnosis)*
- *multiple sclerosis (recurrent episodes with impairment level)*

Heart Conditions

- *angioplasty (triple vessel)**
- *cardiac arrest (out of hospital)**
- *cardiomyopathy (with significant permanent impairment)**
- *coronary artery bypass surgery**
- *heart attack (of specified severity)**
- *heart valve surgery**
- *open heart surgery**
- *aortic surgery**

Cancers and Tumour Conditions

- *benign tumour in the brain or spinal cord (with neurological deficit)**
- *cancer (excluding early stage cancers)**
- *carcinoma in situ of the breast (of specified severity)**
- *chronic lymphocytic leukemia (of specified severity)**

- *melanoma (of specified severity)**
- *prostate cancer (of specified severity)**

Other Serious Conditions

- *chronic kidney failure (end stage)*
- *severe burns (of specified extent)*
- *loss of independent existence*
- *loss or paralysis of limb (permanent)*

The amount we pay is the benefit amount shown on your *policy schedule* at the date the trauma definition is met. Benefits are paid to the *policy owner* and the funds can be used for any purpose.

At the time of your policy *start date,* a *life insured's* Trauma Benefit amount is equal to 30% of their Death and Terminal Illness Benefit amount. Contact us if you would like to change this amount.

We only pay one Trauma Benefit for each *life insured*. Once we pay the Trauma Benefit, we reduce that *life insured's* Death and Terminal Illness Benefit by the same amount as well as reducing the Trauma Benefit to zero. This means your premiums will also go down.

Example: Nancy's story

How the Trauma Benefit amount affects the Death and Terminal Illness Benefit amount

Nancy bought a My Protection Plan policy and is the *life insured*. She has a Death and Terminal Illness Benefit amount of $600,000 and a Trauma Benefit amount equivalent to 30% of the Death and Terminal Illness Benefit. This means her Trauma Benefit amount is $180,000 (being 30% of $600,000).

Ten months after her policy started, Nancy suffered a heart attack that met the definition of *heart attack (of specified severity).* We paid Nancy a Trauma Benefit of $180,000. Nancy's Death and Terminal Illness Benefit reduced by the same amount and is now $420,000 and her Trauma Benefit cover is now $0.

Trauma Benefit qualifying periods for certain conditions

My Protection Plan does not provide a Trauma Benefit for certain conditions which first occur, become *reasonably apparent* or are first diagnosed in the 90 days after:

- your policy *start date*

Please note: Examples are illustrations only.

- the date you increase any benefits, for that increased benefit amount.

The 90-day qualifying period applies to each trauma condition with an asterisk (*) on the list on pages 15 and 16.

Further, we will not pay any benefit for a trauma condition that is directly or indirectly related to a condition which we do not cover because of the 90-day qualifying period explained above.

Example: Charles' story

How trauma qualifying periods apply

Charles bought a My Protection Plan policy. He is the only *life insured* on the policy and is the *policy owner*. Six weeks after his policy *start date*, Charles was diagnosed with *prostate cancer (of specified severity)*. The Trauma Benefit qualifying period applies to this condition. Unfortunately, because it's less than 90 days after his policy *start date*, Charles is not covered and will not receive a Trauma Benefit for this event.

Specified Injury Benefit

My Protection Plan will pay the Specified Injury Benefit if a *life insured fractures* any of the following parts of their body.

- Skull (excluding bones of the face or nose)
- Jaw
- Collar bone
- Shoulder blade
- Upper arm (between the elbow and shoulder)
- Forearm (including wrist but excluding elbow and hand)
- Pelvis
- Upper leg (between the hip and knee)
- Kneecap
- Lower leg (including the ankle but excluding the knee and foot)

The amount we pay is the benefit amount shown on your *policy schedule* at the date the *life insured's specified injury* happens. The benefit is paid to the *policy owner* and can be used for any purpose.

Please note: Examples are illustrations only.

The Specified Injury Benefit is equal to 3% of the *life insured's* Death and Terminal Illness Benefit amount, up to $7,500.

There is no limit to the number of Specified Injury Benefit claims which you can make. However, we will only pay one Specified Injury Benefit for each event, even if a *life insured fractures* multiple parts of their body at any one time.

Example: Tobias' story

How multiple injuries from one event affect the Specified Injury Benefit

Tobias owns a My Protection Plan and is the *life insured*. He is involved in a car accident and *fractures* his collar bone, pelvis and thigh. His treatment includes immobilisation to help all three *fracture*s heal. Even though Tobias' three injuries each meet the definition of *specified injury*, he may only claim for one benefit payment. His benefit payment will be 3% of his Death and Terminal Illness Benefit amount, up to $7,500. Tobias cannot claim a benefit for each injury.

Payment of a Specified Injury Benefit will have no effect on the level or continuation of the other benefits.

Please note: Examples are illustrations only.

WHAT WE DON'T COVER

The following table shows different events or circumstances and whether they are covered under our different benefits.

Where the table talks about increasing benefit amounts, this does not include automatic annual increases (see **'Your cover increases automatically'** on page 8). If your policy has been reinstated after lapse or cancellation, please see **'You can apply to reinstate your policy'** on page 28 for details of what we do not cover.

Event or circumstance	Death and Terminal Illness Benefit	Trauma Benefit	Specified Injury Benefit
Your claim arises directly or indirectly from a *pre-existing medical condition*. See **'Pre-existing medical conditions affect claims'** on page 11.	**Benefit not payable**	**Benefit not payable**	**Benefit not payable**
The event which leads to your claim occurs within 13 months of your policy *start date* (or in the case of a benefit increase, the date of the increase) and is caused by an intentional injury by you or the *life insured* or by suicide.	**Benefit not payable**	**Benefit not payable**	**Benefit not payable**
The event which leads to your claim occurs 13 months or more after the policy *start date* (or in the case of a benefit increase, the date of the increase) and is caused by an intentional injury by you or the *life insured.*		**Benefit not payable**	**Benefit not payable**
The *specified injury* occurs as a direct or indirect result of an act of war.			**Benefit not payable**

Table continues onto next page

Event or circumstance	Death and Terminal Illness Benefit	Trauma Benefit	Specified Injury Benefit
The *specified injury* occurs as a result of the *life insured* participating in criminal activities.			**Benefit not payable**
The *specified injury* occurs as a direct or indirect result of using alcohol or drugs (except where the drugs are taken as prescribed by a *medical practitioner*). This includes conditions related to alcoholism and drug addiction.			**Benefit not payable**
The trauma condition first occurred, became *reasonably apparent* or is first diagnosed in the 90 days after the *policy start date* (or in the case of a benefit increase, the date of the increase). See **'Trauma Benefit qualifying period for certain conditions'** on page 16.		**Benefit not payable**	

Laws can affect the policy

Your policy conditions do not operate to the extent they would require you or Zurich to do something that risks breaking a law relevant to the contract. This applies despite anything to the contrary written in the policy conditions, which are deemed to be varied or nullified to the extent needed to remove the risk of illegality.

In limited cases, current Australian and overseas laws regulating us and other companies in the worldwide Zurich Insurance Group can impose extra requirements on, or restrict us from: accepting premium payments, making claim payments or reimbursements, or conducting other financial transactions on life insurance policies we issue.

Depending on the particular overseas law, they can even extend to people who are not or are no longer living overseas or are only there temporarily. We might also need to suspend or cancel cover when that is the only action that can be taken to comply. In those cases, if the law allows, we would give you prior notice so that you can explain the matters of concern before we act. New or changed Australian or overseas laws may equally affect such policies.

Australian and overseas trade and economic sanctions laws and regulations are one example of laws that might affect a policy we issue. We will not provide any cover, service or benefit for any person that we reasonably consider to be sanctioned by those laws. We will cancel your policy if we reasonably consider that you, a *life insured* or a policy beneficiary are either a sanctioned person or conducting an activity sanctioned by these laws. We would in those cases then allow you, a *life insured* or a policy beneficiary 14 days to show that the person is not a sanctioned person to allow cover to continue.

MAKING A CLAIM

Contact ALI Group to make a claim

Please get in touch with ALI Group to make a claim. Follow these steps:

1. Call or email ALI Group on 1800 006 776 or service@aligroup.com.au and provide the details of your claim.
2. We will send you a claim information pack detailing what will be required to assess your claim and why we need it.
3. Complete the claim form and collect any supporting information that may assist in assessing your claim. See the section **'Information we need for your claim'** on this page.
4. Send the completed claim form and all supporting evidence to us. Make sure all sections are complete.

We will tell you if more information is needed. If the *life insured* needs to be medically examined, we will pay for this.

We may not be able to process a claim if you don't provide us with the information that we've reasonably asked for and is relevant to the claim. We will not pay a claim if an exclusion or qualifying period applies.

Information we need for your claim

The claim forms will ask for the information that we usually need to assess your claim. We may contact you to ask for more information and make reasonable enquiries relevant to the assessment of your claim.

When we assess your claim, we will also rely on any information you gave us as part of your application. If we did not verify information at the time of application, we reserve the right to verify at the time of claim.

You must:

- provide us with all the information we reasonably require to assess your claim
- authorise us to obtain any other information we reasonably need.

This includes information and authorities we may need to investigate any non-disclosure or misrepresentation you or the *life insured* make, which may give us a right to avoid or vary your policy, or to refuse to pay a claim.

The following table shows what information we need for each type of claim.

Type of claim	Information we need
Terminal illness	• Medical evidence from a *medical practitioner* who is a specialist in that condition. The *medical practitioner* must state that the condition is likely to lead to death within 12 months from the date the opinion is provided • A completed claim form • Proof of age of the *life insured*
Death	• A certified death certificate showing the cause of death • A completed claim form • Proof of age of the *life insured*
To get the Funeral Advancement payment	• A death certificate showing the cause of death, or other valid evidence that shows the cause of death • A completed claim form • Proof of age of the *life insured*
Trauma	• Medical evidence from a *medical practitioner* who is a specialist in that condition. The specialist *medical practitioner* must state that the specific requirements of the definition have been met. This may include a required level of severity, test results, or for you to undergo a medical procedure. The specialist *medical practitioner* must state the date that the condition was first diagnosed • A completed claim form • Proof of age of the *life insured*
Specified injury	• Medical evidence from a *medical practitioner*. The *medical practitioner* must state the date that the injury occurred and detail the treatment which is required • A completed claim form • Proof of age of the *life insured*

The documents you submit should be legible, unaltered and include evidence that supports your claim. If we can't use the information you provide for any reason, we will let you know why and will discuss with you what alternative documents can be provided.

To confirm the insured event occurred, where relevant, we may need to have the *life insured* medically examined or get other reasonable tests and reports. We will pay for this.

We will be in contact with you to keep you up to date on our assessment of your claim, and will write to you to tell you the outcome.

You cannot change the *policy owner* if a claim has been submitted and not been finalised.

Examples of claims and how customers could use their benefit

These examples give an idea of how claims are paid.

Example: Anika & Ari's story

How the Death and Terminal Illness Benefit could work if you die

Anika and Ari bought a My Protection Plan policy 13 months ago. They both were the *life insureds*. Each had a Death and Terminal Illness Benefit amount of $374,000 when the policy started.

At the *policy anniversary*, their Death and Terminal Illness Benefit amounts automatically increased to $385,220 each. The increase was 3% of their original Death and Terminal Illness Benefit amounts.

Two months later, Anika died. We paid Ari as the surviving *policy owner* $385,220 (the amount of Anika's Death and Terminal Illness Benefit). Ari's cover continued with no change to his Death and Terminal Illness Benefit but the overall premium reduced because Anika's cover ended.

Example: Carson's story

How the Death and Terminal Illness Benefit could work if you nominate beneficiaries

Carson took out a My Protection Plan policy and was the *life insured*. He nominated his mother and his brother as equal beneficiaries. Carson had a Death and Terminal Illness Benefit of $480,000 at the time he died in a car accident. Carson's mother and brother each received a payment of $240,000.

Example: Jayden's story

How the Death and Terminal Illness Benefit could work if you are diagnosed with a terminal illness

Jayden has a My Protection Plan policy with a Death and Terminal Illness Benefit of $465,000 and is the *life insured*. He is diagnosed with stage 4 cancer and his doctor estimates he has 9 months to live. We pay him $465,000. Jayden uses $400,000 to reduce his debt, $20,000 to buy his wife a new car and $45,000 to take his family on the holiday of a lifetime.

Please note: Examples are illustrations only.

Example: Monique's story

How the Death and Terminal Illness Benefit could work after a Trauma Benefit has already been paid

Monique bought a My Protection Plan policy and was the *life insured*. She had a Death and Terminal Illness Benefit of $600,000. Monique also had a Trauma Benefit of $180,000 which was 30% of the Death and Terminal Illness Benefit.

Ten months after her policy started she suffered a heart attack that met the definition of *heart attack (of specified severity)*. We paid her a Trauma Benefit of $180,000 (30% of $600,000). Monique's Death and Terminal Illness Benefit reduced by the same amount to $420,000.

One month later, Monique died in a car accident. The Death and Terminal Illness Benefit of $420,000 was paid to her estate.

Example: Jeremy's story

How the Trauma Benefit could work

Jeremy has a My Protection Plan and is the *life insured*. He has cover for Death and Terminal Illness Benefit of $428,000 and a Trauma Benefit of $128,400 which is 30% of the Death and Terminal Illness Benefit. Jeremy is diagnosed with *prostate cancer (of specified severity)* as defined under this policy. We pay him a Trauma Benefit of $128,400. He uses some of the money to help him reduce his debt, and pay medical and living expenses while he undergoes treatment and recovers. Jeremy puts the rest of the money into his savings account.

Example: Tamsin's story

How the Specified Injury Benefit could work

Tamsin is a mechanic. She has just settled into her new home and bought a My Protection Plan policy. She is the *life insured*. Tamsin's policy has a Death and Terminal Illness Benefit of $500,000. Because 3% of her Death and Terminal Illness Benefit is greater than $7,500, her Specified Injury Benefit is $7,500.

When working on a car, Tamsin slipped on oil in the workshop and *fractured* her wrist. Tamsin's *fractured* wrist is covered under the Specified Injury Benefit and we pay her the Specified Injury Benefit of $7,500. She uses the money to meet her expenses while she cannot work.

ABOUT YOUR PREMIUM

Your premium is the payment you must make to be covered by My Protection Plan.

How we calculate your premium

We will calculate your premium at the policy *start date* and annually at your *policy anniversary*. If you make changes to your cover, we will recalculate your premium based on the rates applicable at the time of the change.

Your premium usually increases as the *life insured* ages.

Your premium includes a monthly policy fee of $7 which covers the cost of administering your policy. It is included in your premium listed in your *policy schedule*. Only one policy fee is payable for each policy even if it covers more than one *life insured*.

When we calculate your premium, we consider the following factors.

Factor	How this may affect your premium
The *life insured's* age	The *life insured's* current age affects your premium. Generally, as they get older, your premium will increase. We calculate your premium based on the *life insured's* age when you apply for My Protection Plan. We re-calculate your premium at each *policy anniversary* date in line with the *life insured's* increase in age.
The *life insured's* gender	The *life insured's* gender affects your premium. Generally, premiums for males are higher than premiums for females of the same age.
Benefit amounts nominated for each *life insured*	The amount of the *life insured's* Death and Terminal Illness Benefit and Trauma Benefit affects your premium. The higher the benefit amount, the higher your premium will be. We re-calculate your premium at each *policy anniversary* in line with any increase in benefits, or at any other time that your benefit amounts change.
The *life insured's smoker* status	Whether or not the *life insured* smokes affects your premium. Higher premiums apply for those who have smoked cigarettes, e-cigarettes, nicotine replacements or any other substance in the last 12 months. We ask the *life insured's smoker* status in the My Protection Plan application. If the *life insured* was a *smoker* at that time, but has stopped smoking for 12 months or more, you should tell us and we will re-calculate your premium based on the non-smoker rate.
Discounts	Discounts may be available to ALI Group staff and representatives and, if applicable, will be shown on the *policy schedule*. Any discounts are not guaranteed and may be removed or changed.
Government charges and stamp duty	Unless we say otherwise, the premium you pay is inclusive of any applicable stamp duty, tax, excise or government charges that apply to this policy. Goods and Services Tax (GST) is not currently payable on insurance premiums for the policy described in this *PDS*. We reserve the right to alter premium rates or add any new government charges to comply with changes in legislation.

At the policy *start date*, we calculate premiums as a specified rate for each $100,000 of the Death and Terminal Illness Benefit amount. If you'd like to see a table of premium rates and information on how we calculate them, let ALI Group know.

How you pay your premium

You pay us your premium in advance by direct debit from a bank account or credit card. Your first premium is due 1 month after your policy *start date*.

The terms of the authorisation for Zurich Australia Limited to deduct premiums are in the **'Direct Debit Service Agreement'** on page 44. You have the right to stop premium payments as detailed in the Direct Debit Services Agreement.

To make sure we can process changes in time, please tell us about any changes to your direct debit details 14 days before your next premium payment is due.

In the event of the *life insured's* death, we will refund any premiums collected from the date the *life insured* died, once we are notified of the *life insured's* death.

What happens if you miss paying a premium

If you miss a premium payment, we may attempt to debit your nominated bank account or credit card a second time. If this is unsuccessful, ALI Group will contact you about how you can pay your outstanding premiums.

If you do not pay the premium on the due date, we may cancel your policy (see **'How you pay your premium'** on this page). If we decide to cancel your policy for nonpayment of premium, then before we do, we will:

- write to you and give you at least 30 days notice, and
- give you the opportunity to pay the premium.

We won't cover any events that happen after your policy is cancelled.

If you do not pay the missed premium and a claim arises after the policy cancellation, we may refuse the claim.

Avoid a policy lapse

If you have questions about your cover and benefits or are having difficulty paying your premium, there are options available under your policy to help. For example, your benefit amounts may be adjusted to reduce your premium. Please contact ALI Group for more help.

You can apply to reinstate your policy

We have the right to choose to reinstate your policy if your policy ends because:

- you cancel your policy
- we cancel your policy because we do not receive your premium when due.

Before reinstating your policy:

- we may ask you for more information
- you must pay all outstanding premiums.

If we reinstate your policy, we will confirm it in writing. We treat the reinstated policy as a continuation of the original policy that lapsed, subject to the law at that time.

Once we reinstate your policy, a 90-day qualifying period will apply. This means that no benefit

will be payable for any *terminal illness* or trauma condition if symptoms first occur or become *reasonably apparent*, or that are diagnosed within 90 days from the *reinstatement date*.

Your policy will not be reinstated more than 45 days after it has ended.

Changes to your premium rates and policy fee

Your premium may change in the following situations.

- If your benefit amounts change
- As the *life insured* gets older
- If the *life insured* was previously a *smoker* and you have notified us that they no longer smoke - see **'How we calculate your premium'** on page 26
- If we change the premium rate for all products issued under this version of the *PDS*

Premium rates and the policy fee are not guaranteed and can change from time to time. We may change the premium and policy fee for all products issued under this version of the *PDS*.

Factors which can affect premium rates and the policy fee include changes in these things.

- Costs we must pay to provide your cover, such as the cost of claims; the amount we pay in claims will be higher than expected if:
    - we pay more claims than expected
    - we pay higher benefit amounts than expected
- Emerging industry experience and trends show an increase in the long term cost of claims
- Commission costs
- Operating costs
- Capital and regulatory requirements
- Expected policyholder behaviour across the portfolio, including how long cover is held
- Economic factors such as interest rates, inflation rates, employment level and market returns
- Tax, government, or other mandatory charges
- Other factors we consider important to continue providing cover and paying claims for My Protection Plan.

Any change, however, will affect all policies in the same category issued under this version of the *PDS*, not just an individual policy. If we do this, we will give you at least 30 days' notice of any increase in the premium.

Your premium is not tax deductible and benefits don't count as income

If you hold your policy for personal purposes, the premium is usually not tax deductible.

Benefits you get paid are usually not assessable as income or capital gains.

We base this on our views of the way current tax laws are interpreted. Tax law interpretations change over time. If this is important to you, seek independent tax advice about your circumstances.

This policy does not have a surrender value

You cannot redeem this policy for a lump-sum payment, and you don't receive a payment when the policy ends. The only payments you can get under this policy are claim payments under the:

- Death and Terminal Illness Benefit
- Trauma Benefit
- Specified Injury Benefit.

Cancelling your policy

You can cancel your policy at any time. The table below shows what you need to remove cover for a *life insured* or to cancel your policy, depending on your situation.

Situation	What you need
You are the only *policy owner*, and you want to cancel your cover.	If your policy provides cover for two *life insureds*, you can cancel the cover for only one of them at any time. You can cancel the policy at any time.
Two *policy owners* own the policy covering two *life insureds*, but only want to cancel cover for one *life insured*.	Both *policy owner*s must agree to cancel cover for the *life insured*. We'll change the policy to reflect that the cover for that *life insured* has been cancelled. Cover for the remaining *life insured* will continue. Your premium will decrease.
Two *policy owners* own the policy, it covers two *life insureds* and you want to cancel cover for everyone. This means you want to cancel the policy.	Both *policy owner*s must agree to cancel the policy.

How to cancel your policy

Contact ALI Group to request to remove cover for a *life insured* or cancel your policy. You will need to provide:

- policy number
- name and address of every *policy owner* and *life insured*
- signatures or authority of all *policy owner*s.

Cancelling your policy during the cooling off period

If you cancel a policy within 30 days from the policy *start date* you will not need to pay any premium. These 30 days are the 'cooling-off' period. Contact ALI Group to cancel the policy or a *life insured's* cover.

If you cancel your policy after the cooling-off period, we will not refund any premium you have paid. The date your policy ends will depend on the period of cover that you have paid premiums for.

WE FOLLOW THE LIFE INSURANCE CODE OF PRACTICE

Life Insurance Code of Practice

Zurich Australia Limited has adopted the Life Insurance Code of Practice.

This Code sets out the life insurance industry's key commitments and obligations to customers. These include:

- standards of practice
- standards of disclosure
- principles of conduct for our life insurance services, such as being open, fair and honest.

It also sets out timeframes for insurers to respond to customers about claims, complaints and requests for information.

The Code also contains medical definitions for certain conditions. This means that when you make a claim under one of the conditions covered by the Code, we will assess your claim against the better of the following definitions:

- the applicable definition in the PDS
- the corresponding medical definition in the Code that is current at the time of the illness or injury.

You can get a copy of the Life Insurance Code of Practice from the Council of Australian Life Insurers website at cali.org.au.

HOW YOU CAN CONTACT US FOR MORE INFORMATION

Please contact ALI Group with your questions, concerns, or feedback.
ALI Group's contact details are:

ALI Group
GPO Box 4737
Sydney NSW 2001
Phone: 1800 006 776
Email: service@aligroup.com.au

How you can make a complaint

Zurich Australia Limited and ALI Group value your feedback about the help and support we provide. We're both committed to working with you and resolving any concerns you may have.

Contact ALI Group using the details above if you would like to make a complaint.

They will do their best to resolve your concerns genuinely, promptly, fairly and consistently. They will keep you informed of the progress as they work with you.

Further help - Australian Financial Complaints Authority (AFCA)

If your concerns have not been resolved to your satisfaction, you can lodge a complaint with AFCA. AFCA provides fair and independent financial services complaint resolution that is free to consumers.

AFCA contact details are:

Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001
Phone: 1800 931 678
Email: info@afca.org.au
Website: afca.org.au

Time limits may apply to complaints to AFCA. Make sure you act promptly. Check the AFCA website to see if there is a time limit for your situation, and when the time limit expires.

PROTECTING YOUR PRIVACY

For the purposes of this statement, 'we', 'our' and 'us' means Zurich Australia Limited, ALI Group and its related bodies corporate and anyone collecting information on our behalf.

In this section the words 'you' and 'your' refer to the *policy owner* and the *life insured*.

Please read the information in this section carefully: it describes how each of these parties will handle your personal information.

In this section, your personal information includes any health or other sensitive information that we may hold about you.

We are bound by the Privacy Act 1988 (Cth). Before providing us with any personal or sensitive information (information), you (including any person information is being provided about as part of the application) should know the following.

We will only collect your information for specific purposes

We collect, use, process and store personal information and, in some cases, sensitive information about you for the following purposes.

- Complying with our legal obligations
- Providing premium quotes
- Assessing your application for insurance cover
- Issuing and administering the insurance cover provided
- Enhancing our customer service or products
- Providing information about our products
- Helping to administer and manage claims

If you do not agree to provide us with the information, we may not be able to process your application, administer your cover or assess your claim.

You can ask us to not use your information to tell you about other products

We may use your personal information (but not sensitive information) to tell you about other products and services we offer.

Please contact us if you do not want us to use your personal information in this way.

Who we collect your personal information from

Usually we'll collect your personal information from you when you make an application, or complete a personal statement. We may collect it face-to-face, over the phone or online.

We may also collect it from a third party, such as your mortgage broker, loan consultant, financial adviser, health professional, accountant or another organisation we have an arrangement with.

We may also collect information from government offices and third parties to assess an application or claim.

Who we may share your information with

By providing us with your information, you consent to our use of this information which includes us disclosing your information where it's relevant. See **'We will only collect your information for specific purposes'** on page 33. Where relevant, we may disclose your information to.

- other *policy owners* or the *life insured*
- your mortgage broker or loan consultant
- affiliates of the Zurich Insurance Group Ltd
- other insurers and reinsurers
- our service providers
- *medical practitioners*
- our banking gateway providers and credit card transaction processors
- our business partners
- anyone else as required by law within Australia or overseas.

Anyone we outsource tasks to must meet our privacy requirements when they use your information. This includes only using your information for the tasks we outsource to them.

Australian laws that cover collecting personal information

The Australian laws that cover collecting personal information include the following Acts as they are amended, and any associated regulations:

- Australian Securities and Investment Commissions Act 2001
- Corporations Act 2001
- Insurance Contracts Act 1984
- Life Insurance Act 1995
- Anti Money Laundering and Counter Terrorism Financing Act 2006
- Anti Money Laundering and Counter Terrorism Financing Rules Instrument 2007 (No. 1)
- Income Tax Assessment Act 1997
- Taxation Administration Act 1953

Sometimes other acts may require or authorise us to collect your personal information.

Learn more about our Privacy Policies

For further information about our Privacy Policies, a list of service providers and business partners that we may disclose your information to, a list of countries in which recipients of your information are likely to be located, and/or details of how you can access or correct the information we hold about you, please refer to:

Zurich Australia Limited

Privacy link on our homepage – zurich.com.au
Contact us by telephone on 132 687
Email us at privacy.officer@zurich.com.au

ALI Group

Privacy link on our homepage – aligroup.com.au
Contact us by telephone on 1800 006 776
Email us at service@aligroup.com.au

We want to keep in touch

How we communicate with you

If you have given your email address, we may send updates about your policy to your inbox. We will still need to send some communication by post and may sometimes send both an email and a letter.

You can let us know that you don't want updates via email, and we will send them to the postal address you last gave us.

If we don't have your email address, we will send updates to the postal address you last gave us.

Any notice we send by post will be considered effective on whichever comes first.

- The day it arrives.
- The day it should have arrived based on regular postal delivery times.

We may also send communication such as overdue premium reminders to the mobile number you gave us. If you don't want to receive any SMS communications, please tell us.

Please call or write to us to let us know if any of your contact details are incorrect or change, or if you want to change the way we communicate with you.

DEFINITIONS OF THE TERMS IN THIS PDS

This section tells you the special definitions of terms that appear in this *PDS* in *italics*.

A

Alzheimer's disease - dementia (diagnosis and with cognitive impairment)

Means the unequivocal diagnosis of dementia or Alzheimer's disease that meets all the following:

- is characterised by the presence of marked impairment of cognitive functioning evidenced by a Mini Mental State Examination (MMSE) score of 20 or less; or the results of an equivalent neuro-psychometric test
- the *life insured* requires continual supervisory care by another adult person as the result of cognitive impairment
- the condition must be permanent and associated with an underlying disease of the nervous system
- the diagnosis must be made by a consultant neurologist or geriatrician.

Angioplasty (triple vessel)

Means the actual undergoing of angioplasty to three or more coronary arteries (left main, left anterior descending, circumflex and right coronary) or their branches, within the same procedure or via two procedures no more than three months apart. Angiographic evidence showing obstruction is required to confirm that the procedure is medically necessary.

Aortic surgery

Surgical repair to the aorta to correct any narrowing, dissection or aneurysm of the aorta but does not include angioplasty, intra-arterial procedures including endovascular abdominal aorta repair or other non-surgical techniques. For the purposes of this definition, aorta shall mean the thoracic or abdominal aorta, but none of its branches.

B

Benign tumour in the brain or spinal cord (with neurological deficit)

Means a non-malignant tumour in the brain or spinal cord, which is histologically described, and which produces neurological deficit, resulting in one of the following:

- a permanent and irreversible inability to perform at least one of the activities of daily living (as outlined under the *loss of independent existence* definition)
- the undergoing of surgery to remove the tumour.

The impairment must be certified by an appropriate specialist *medical practitioner*.

The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI or other equivalent diagnostic investigation.

We do not cover any of the following:

- Cysts, granulomas and cerebral abscesses
- Malformations in, or of, the arteries or veins of the brain
- Hematomas
- Tumours in or arising from the pituitary gland (including pituitary neuroendocrine tumours). Tumours in or arising from the pituitary gland are covered only if the *life insured* undergoes total surgical removal by open craniotomy.

C

Cancer (excluding early stage cancers)

Means the presence of a malignant tumour, including leukaemia, malignant lymphoma and other haemopoietic malignancies.

The tumour must be both:

- confirmed by histological examination or appropriate pathological testing in the case of non-solid tumours
- characterised by the uncontrolled growth of malignant cells and invasion and destruction of normal tissue.

The severity of the condition will mean either:

- the *life insured* must require major interventionist therapy such as surgery to remove the tumour, radiotherapy, chemotherapy, biological response modifiers or any other major treatment.
- the tumour must be sufficiently advanced such that major interventionist therapy is no longer recommended.

The following cancers are specifically excluded.

- Tumours which are histologically classified as 'pre-malignant', 'non-invasive', 'high-grade dysplasia', 'borderline' or 'having low malignant potential'
- Chronic lymphocytic leukaemia other than as defined by *chronic lymphocytic leukaemia* (*of specified severity*)
- All cancers described as carcinoma in situ other than as defined by *carcinoma in situ of the breast* (*of specified severity*)
- All cancers of the prostate other than as defined by *prostate cancer* (*of specified severity*)
- All melanomas other than as defined by *melanoma* (*of specified severity*)
- All Hyperkeratosis or Basal Cell Carcinoma (BCC) of skin and Squamous Cell Carcinoma (SCC) of skin unless having spread to the bone, lymph node, or another distant organ
- All cancers of the thyroid unless:
  a) having progressed to at least TNM classification T2N0M0 (Stage II)
  b) where total thyroidectomy has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment.
- All cancers of the bladder unless having progressed to at least TNM

classification T1N0M0 (Stage I)

- Cutaneous lymphoma confined to the skin
- All pituitary neuroendocrine tumours unless one of the following applies:
  a) there must be evidence of metastatic spread
  b) open craniotomy is required to remove the tumour.

The diagnosis must be confirmed by a specialist *medical practitioner.*

Carcinoma in situ of the breast (of specified severity)

Carcinoma in situ of the breast only if it requires any of the following.

- The removal of the entire breast, including nipple sparing mastectomy
- Breast conserving surgery and radiotherapy
- Breast conserving surgery and chemotherapy (chemotherapy means the use of drugs specifically designed to kill or destroy cancer cells)

Carcinoma in situ of the breast treated by breast conserving surgery and other forms of adjuvant systemic therapy, including endocrine manipulation therapy, hormonal manipulation therapy or non-endocrine adjuvant therapy, is not covered.

Cardiac arrest (out of hospital)

Cardiac arrest (cessation of cardiac function resulting in loss of consciousness, loss of respiratory effort and loss of signs of circulation) that is not associated with any medical procedure, occurs out of hospital or any other medical facility, and is documented by an electrocardiogram (ECG) showing asystole or ventricular fibrillation.

If an ECG is not available, we will consider medical evidence which is acceptable to us as confirming that an out of hospital cardiac arrest has occurred. Examples of suitable evidence include but aren't limited to:

- Ambulance and hospital medical reports confirming cardiac arrest
- Documentation of the administration of Cardiopulmonary Resuscitation (CPR) by an attending ambulance officer or hospital clinical staff
- Automated External Defibrillator (AED) data

Cardiac arrest related to alcohol, drug or medication abuse is excluded.

Cardiomyopathy (with significant permanent impairment)

A permanent and irreversible condition of impaired ventricular function of variable aetiology (often not determined) resulting in either:

- significant physical impairment that is at least Class III on the New York Heart Association classification of cardiac impairment
- a left ventricular ejection fraction of less than 40%.

Cardiomyopathy directly related to alcohol abuse is excluded.

The diagnosis must be confirmed by a specialist *medical practitioner.*

Chronic

A condition that is recurrent, has lasted more than 1 month or requires ongoing prescribed medication or treatment.

Chronic lymphocytic leukaemia (of specified severity)

The presence of chronic lymphocytic leukaemia diagnosed as at least Rai stage I, which is defined to be in the blood and bone marrow only.

Chronic kidney failure (end stage)

Means end stage renal failure presenting as *chronic* irreversible failure of both kidneys to function. The condition must require one of the following:

- Lifelong regular renal dialysis; or
- Renal transplantation.

The diagnosis must be confirmed by a specialist *medical practitioner*.

Coronary artery bypass surgery

The actual undergoing of by-pass graft surgery, either through an open heart operation procedure or through a 'key-hole' surgical technique, to two or more blocked coronary arteries causing inadequate myocardial blood supply.

CPI

The Consumer Price Index. This is the weighted average of Australia's eight capital cities as published by the Australian Bureau of Statistics or its successor. If the CPI is not published, the increase will be calculated by reference to another retail price index that our Appointed Actuary decides most nearly replaces it.

E

Eligible loan

A home loan, investment property loan, commercial loan or equity access loan.

F

Fracture

Any fracture resulting from an accident and requiring fixation, immobilisation or plaster cast as treatment.

H

Heart attack (of specified severity)

The death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area, measured by the tests specified below, where the diagnosis is supported by a diagnostic rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least three of the following.

a) Symptoms of ischaemia consistent with myocardial infarction

b) ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block)

c) Development of new pathological Q waves on the ECG

d) New regional wall motion abnormality persisting for at least 6 weeks and confirmed on cardiac imaging including echocardiogram, cardiac CT, cardiac MRI or cardiac radio nuclear scan

If the tests specified are inconclusive or unable to be met, then the definition will be met if 3 months after the event the *life insured's* left ventricular ejection fraction is less than 50 per cent.

The following are not covered:

- A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease
- Other acute coronary syndromes

including but not limited to angina pectoris.

The diagnosis must be confirmed by a specialist *medical practitioner*.

Heart valve surgery

Means surgery considered medically necessary to repair or replace cardiac valves due to heart valve defects or abnormalities that can't be corrected by non-surgical techniques.

Heart valve surgery doesn't include angioplasty or intra-arterial procedures.

L

Life insured

The person or persons listed as the insured person on the *policy schedule*. They are the person(s) whose death, *terminal illness*, trauma or injury may cause us to pay a benefit.

Loss of independent existence

The *life insured* is totally and permanently unable to perform independently two or more activities of daily living.

The activities of daily living are:

- bathing – the ability to shower or bathe
- dressing – the ability to put on or take off clothing
- toileting – the ability to use the toilet, including getting on or off
- mobility – the ability to get in and out of bed and a chair
- continence – the ability to control bladder and bowel function
- feeding – the ability to get food from a plate into the mouth.

Loss or paralysis of limb (permanent)

Means the total and permanent loss of use of a whole hand or a whole foot as a result of illness or injury, or the total and permanent loss of the use of one arm or one leg as a result of paralysis.

M

Medical consultation

Medical consultation means any activity specific to detecting, treating, or managing of any illness, injury, medical condition or related symptoms. This includes but is not limited to taking of prescribed drugs or receiving therapy (whether conventional or alternative). A medical consultation does not include routine medical check-ups unless it leads to the detection of illness, injury, medical condition or related symptoms.

Medical practitioner

Means one of the following:

- medical practitioner legally registered to practise in Australia
- a medical practitioner legally registered to practise in another country who has an equivalent qualification.

Medical practitioner generally includes the *life insured's* general practitioner and any treating specialists involved in diagnosis and management of their condition.

Where we need an opinion from a medical specialist appropriate to the medical condition, we'll let you know.

Medical practitioner doesn't include:

- the *policy owner*, their relative, business partner or employee
- the *life insured*, their relative, business partner or employee

- other para-medical professionals including (but not limited to) psychologists, chiropractors, physiotherapists, or naturopaths.

Melanoma (of specified severity)

The diagnosis of a malignant melanoma of stage T1bN0M0 or higher.

Motor neurone disease (diagnosis)

Means unequivocal diagnosis of a motor neurone disease, as confirmed by a *medical practitioner* who is a consultant neurologist.

Multiple sclerosis (recurrent episodes with impairment level)

Means the unequivocal diagnosis of multiple sclerosis confirmed by a consultant neurologist.

Diagnosis must be supported by confirmatory neurological investigations such as lumbar puncture, MRI (Magnetic Resonance Imaging), evoked visual responses and evoked auditory responses. There must be more than one episode of well-defined neurological deficit with persisting neurological abnormalities.

O

Open heart surgery

Means the undergoing of open heart surgery that is considered necessary to correct a cardiac defect, cardiac aneurysm or cardiac tumour.

P

Partner

A spouse or de-facto spouse where one or both partners provide each other with financial support, domestic support and personal care.

PDS

This document, the Product Disclosure Statement and Policy Document.

Policy anniversary

The annual anniversary of the policy *start date*.

Policy owner

The person or persons who owns the policy as noted on the *policy schedule*. If the policy is owned by more than one person, it will be held jointly. The policy owner is responsible for making premium payments and is entitled to receive any benefits which become payable. When the policy is held by joint policy owners, in the event that one policy owner dies, the policy ownership transfers to the surviving policy owner.

Policy schedule

The document provided to you at the start of your policy or the most recent *reinstatement date* (if your policy has been reinstated). The policy schedule includes:

- your name and address
- the name of each *life insured*
- the *start date* of the policy
- the annual and monthly premium amounts
- the monthly policy fee
- the date the first premium is due
- the individual benefit amounts.

Pre-existing medical condition

An illness, injury or condition that was the subject of a *medical consultation* in the 5 years immediately before the policy *start*

date or benefit increase date (to the extent of the benefit increase), and:

- the *life insured* was aware of; or
- a reasonable person in the circumstances could be expected to be aware of.

Prostate cancer (of specified severity)

Prostate cancer having progressed to T2 on the TNM Clinical Staging System; or histologically classified as having a Gleason Score of 7 or higher; or having resulted in the surgical removal of the prostate (where it was considered by treating doctors to be the appropriate and necessary treatment).

R

Reasonably apparent

A reasonable person in the circumstances could be expected to have been aware of the symptoms.

Reinstatement date

The date we grant the *policy owner*'s request to reinstate the policy. We will confirm the reinstatement date to you in writing.

S

Severe burns (of specified extent)

Tissue injury caused by thermal, electrical or chemical agents causing full thickness burns to either:

- 20% or more of the body surface area as measured by the 'Rule of Nines' or the Lund and Browder Body Surface Chart
- 50% or more of both hands, requiring surgical debridement and/or grafting
- 50% or more of both feet, requiring surgical debridement and/or grafting
- 50% or more of the face, requiring surgical debridement and/or grafting
- the whole of the skin of the genitalia, requiring surgical debridement and/or grafting.

Specified injury

A *fracture* to:

- skull (excluding bones of the face and nose)
- jaw
- collar bone
- shoulder blade
- upper arm (between the elbow and shoulder)
- forearm (including wrist but excluding elbow and hand)
- pelvis
- upper leg (between the hip and knee)
- kneecap, or
- lower leg (including the ankle but excluding the knee and foot).

The diagnosis must be confirmed by a *medical practitioner*.

Smoker

A person who has smoked cigarettes, e-cigarettes, nicotine replacements or any other substance in the last 12 months.

Stroke (of specified severity)

Death of brain tissue resulting from insufficient blood supply (typically due to a thrombus or clot), bleeding within the skull, or intracerebral embolism, and that has resulted in permanent neurological impairment. This diagnosis must be supported by both of the following.

- Evidence of permanent neurological deficit with persisting clinical symptoms confirmed by a neurologist at least 6 weeks after the stroke
- Findings on Magnetic Resonance Imaging (MRI), Computerised Tomography (CT), or other reliable imaging techniques consistent with the diagnosis of a new stroke and compatible with the neurological deficit

The following are excluded.

- Transient ischaemic attacks
- Cerebral events and symptoms due to reversible neurological deficits and migraine
- Vascular disease affecting the eye or optic nerve
- Ischaemic disorders of the vestibular system
- Any stroke related to recreational drug use and substance abuse or both
- Brain damage due to an accident or injury

Start date

The "Commencement Date" listed on your *policy schedule*.

T

Terminal illness

That in the opinion of a specialist *medical practitioner* the *life insured* is terminally ill or injured, and as a result of the terminal illness or injury, despite all reasonable medical treatment, the *life insured* is not expected to live more than 12 months.

DIRECT DEBIT SERVICE AGREEMENT

This section includes the terms of the authorisation for Zurich Australia Limited User ID 620927, ABN 92 000 010 195 to debit premiums from your *account*.

In this section, the words 'you' and 'your' refer to the customer who authorised the *Direct Debit Request* and the words 'we', 'our' and 'us' refer to Zurich Australia Limited.

In this section, words in italics are defined at the end of this Direct Debit *Agreement*, on page 47.

Authorisation

By providing us with the *Direct Debit Request*, you have authorised us to arrange for funds to be debited from your *account* for the purpose of paying the premiums on the insurance cover provided by your My Protection Plan. The authorisation will be on the terms set out in this *agreement* and may be provided to us in writing, electronically or verbally. Any change to the *account* to which your *Direct Debit Request* applies may also be provided to us in writing, electronically or verbally.

We will not issue a billing notification before we debit the premium. If the *premium due date* falls on a non-*business day*, we will debit the premium on the next *business day*. If you are not sure when a premium will be debited, please check with us or your *financial institution*.

The amount of the premium may change, and we will not tell you about these changes unless the terms of the Product Disclosure Statement and Policy Document require us to do so.

We only debit the amounts that you have authorised

We will only debit from your *account* those amounts that you have authorised under the *Direct Debit Request*. Except in the circumstances permitted by the Product Disclosure Statement and Policy Document, we will not change the amount or frequency of the debiting arrangements, without your prior approval.

You cannot change how much or how often we debit your account

Importantly, your premium is charged monthly, fortnightly or weekly. The amount charged to your *account* will be for the premium due under the policy.

We may change the terms of this agreement

We may change the terms of this *agreement* with 30 days prior notice. Any change will only affect new debits from the date of change. If we change the terms, we will tell you the options that are available to you at that time.

Debiting arrangements

The only amount we will debit from your *account* is the full premium due. If your *financial institution* dishonours the debit, we may choose to try to debit the amount from your *account* again.

We can cancel this authorisation if 3 or more attempts to debit the premium are unsuccessful.

We keep your account information confidential

We will keep all information relating to your *account* confidential and will only use the information for purposes connected with this *agreement* and the insurance.

However, our *financial institution* may also need this information if a claim is made against it relating to an alleged incorrect or wrongful debit. Our Privacy Policy will apply to this information.

You can cancel this authorisation, change account details, and defer or stop a debiting

Tell ALI Group in writing, either directly or through your *financial institution*, at least 14 days before the *premium due date* if you want to do any of the following.

- Cancel the authorisation
- Change the *account* details to which the authorisation applies
- Stop or defer us debiting your *account*

Contact ALI Group if you think there's been an error

Contact ALI Group if you think there has been an error in debiting your *account*. If you find we have incorrectly debited your *account*, ALI Group will confirm in writing how the error will be fixed.

If you're not satisfied in the way your matter was resolved, you can contact your *financial institution*. You can also lodge a Direct Debit Claim through your *financial institution*.

Your responsibilities

Under this Direct Debit Service Agreement, you have the following responsibilities.

Make sure your account details are correct

You must make sure direct debiting through BECS is available on your *account* and the *account* details you have given are correct. You should check your *account* details to a recent *account* statement, or check with your *financial institution* if you are unsure.

Have enough money in your account on each premium due date

You must make sure enough money is available in the *account* to be debited each *premium due date*. If there isn't enough money and the payment is dishonoured, you will be responsible for any fee the *financial institution* charges to your *account*. You will also be responsible for any fee that we incur, and we are authorised to recover this from your *account*.

Make sure you're able to authorise us to debit from the account

You must make sure the person or people who have given us authorisation to debit from the *account* can do so under the *account* signing instructions that your *financial institution* holds.

Tell us if the account is transferred or closed

You must tell us if the *account* is transferred or closed.

Find another way to pay premiums if you want to cancel this authorisation

If you want to cancel this authorisation, you will need to arrange for an alternative means of paying your premiums so your policy can continue.

Make sure we debit the correct amounts

Check your *account* statement to verify the amounts we debit are correct.

Pay fees and charges

You must pay any fees or charges your *financial institution* makes to your *account* in connection with the debits made on your *account*.

Definitions of the terms in this Direct Debit Service Agreement

Account

The account held at your *financial institution*, from which we are authorised to debit funds.

Agreement

This Direct Debit Request Service Agreement between you and us.

Business day

A day other than a Saturday, Sunday or a public holiday in New South Wales.

Direct Debit Request

The written, verbal or electronic request from you to us to debit funds from your *account*.

Financial institution

The financial institution where you hold your *account*, and that you have authorised us to debit.

Premium due date

The day your payment to us is due.

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